

471-000-10 Instructions for Completing the Nebraska Medicaid Telehealth Patient Consent Form

Use: The Nebraska Medicaid Telehealth Patient Consent Form may be used by any Nebraska Medicaid provider when providing telehealth services to a Medicaid client. Providers may make a copy of this form for their use. If another form is used, all elements required in regulations must be included. (See 471 NAC 1-006.10A Informed Consent.)

Number Prepared: One original and a copy.

Completion: The appropriate person at either the client site or the health care practitioner site completes the form and obtains the client's signature prior to the service.

1. Enter the client's name on the first line.
2. Define the service to be provided as a telehealth service on the second line; for example, specialty physician consultation, speech therapy.
3. Enter the name of the health care practitioner who will be seeing the client from the distant site on the third line.
4. Enter the facility name and address of the distant site where the health care practitioner is located on the fourth line.
5. Describe in writing any other options that are available to the client in the space provided in the middle of the form.
6. The client, the parent, or the legal representative must sign and date the form.
7. The person obtaining the consent must sign and date the form and enter his/her facility name and address.

Distribution: The original form is completed by the provider of the telehealth service and is retained in the client's medical record. A copy of the form is given to the client or parent/guardian.

Retention: The provider retains the original form in the client's medical record .

**Sample
Nebraska Medicaid Telehealth
Patient Consent Form**

I (name) _____ agree to receive this health care service, (type of service) _____, as a telehealth service. I understand that the health care practitioner (name) _____ is located in another location (facility name and address) _____.

_____. A telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for six months for follow-up telehealth services with the health care provider.

I also understand that:

- I can decline the telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care practitioner in-person if I decline the telehealth service.
- If I decline the telehealth services, the other options/alternatives available for me, including in-person services, are as follows:

- The same confidentiality protections that apply to my other medical care also apply to the telehealth service.
- I will have access to all medical information resulting from the telehealth service as provided by law.
- The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my additional written consent.
- I will be informed of all people who will be present at all sites during my telehealth service.
- I may exclude anyone from any site during my telehealth service.
- I may see an appropriately trained staff person or employee in-person immediately after the telehealth service if an urgent need arises OR I will be told ahead of time that this is not available.

I have read this document carefully, and my questions have been answered to my satisfaction.

Signature of Patient _____
Date _____

Or
Signature of Parent or Legal Representative _____
Date _____

Telehealth Consent:
Signature of Person Obtaining Consent _____
Date _____

Facility Name _____
Facility Address _____